

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL
FOR: HEALTH CARE FINANCING ADMINISTRATION**

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2. STATE:

MA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL
SECURITY ACT (MEDICAID)

Title XIX

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

July 1, 1998

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 447.250-299

7. FEDERAL BUDGET IMPACT:

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b. FFY \$

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A(3)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):

Same

10. SUBJECT OF AMENDMENT:

State-Owned Nonacute Hospital Payment Methods

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL☒ OTHER, AS SPECIFIED:

Not required under 42CFR 430.12(b)(2)(i)

12. SIGNATURE OF STATE AGENCY OFFICIAL:



13. TYPED NAME:

Bruce M. Bullen

14. TITLE:

Commissioner

15. DATE SUBMITTED:

September 29, 1998

16. RETURN TO:

Bridget Landers
State Plan Coordinator
Division of Medical Assistance
600 Washington Street
Boston, MA 02111**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

9/30/98 Hand Carried

18. DATE APPROVED:

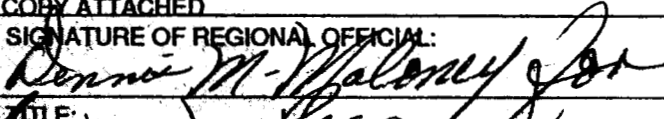
JUN 06 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

July 1, 1998

20. SIGNATURE OF REGIONAL OFFICIAL:



21. TYPED NAME:

Ronald P. Preston

22. TITLE:

Associate Regional Administrator, DMSO

23. REMARKS:

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State Plan Under Title XIX of the Social Security Act
Massachusetts Medical Assistance Program

**Methods Used to Determine Rates of Payment
for Services in State-Owned Nonacute Hospitals**

I. General Description of Prior and Current Payment Methodology

The following sections describe the methods and standards utilized by the Division of Medical Assistance ("Division") to establish rates of payments by contract, to be effective July 1, 1998 (Rate Year (RY) 1999), for services rendered by State-owned non acute hospitals to patients entitled to medical assistance under the M.G.L. c. 118E, §1 *et seq.* State-owned non acute hospitals participating in the Massachusetts Medical Assistance Program include chronic disease and rehabilitation hospitals and psychiatric hospitals.

1. Hospital allowable costs, with the exception of the working capital component, are determined from a base year that has been fixed at FY93. Expenses disallowed in the base year are never rolled into payment rates for subsequent years. The establishment of a fixed-base year, therefore, provides a strong incentive for cost efficiency. Rates of payment are adjusted to affect appropriate cost increases or decreases resulting from changes in volume, case-mix, inflation, and other factors. The working capital component is determined from the operating and capital requirements of the rate year.
2. Rates of payment have a direct relationship to the actual charges incurred by a patient based on the services utilized by that patient. Under this charge-based system hospitals are able to charge more for patients who require more or heavier care. Thus, this system is responsive to hospital financial needs in the face of changing casemix.
3. A payment-on-account factor (PAF), essentially a ratio of allowed hospital costs to allowed hospital charges, is also

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calculated for each hospital. A single payment-on-account factor will apply to a hospital's inpatient and outpatient services; Medicaid reimbursement will be equal to charges (or daily charge) times the payment-on-account factor. In no event shall the PAF exceed 100% of a hospital's charge for services.

II. Definitions

Adjusted Base Year Volume. The actual base year volume adjusted to include the volume associated with recurring CBCs, new services and transfers on of cost and exclude volume associated with Discontinued Services and transfers off of cost.

Base Year. Base year shall mean the hospital's fiscal year 1993.

CBC. Cost Beyond Control.

Charge. The amount to be billed or charged by a hospital for each specific service within a revenue center.

Department of Mental Health (DMH). An agency of the Commonwealth of Massachusetts established under M.G.L. c. 19, §1 *et seq.*

Department of Public Health (DPH). An agency of the Commonwealth of Massachusetts established under M.G.L. c. 17, §.1.

Division of Health Care Finance and Policy (DHCFP). An agency of the Commonwealth of Massachusetts established under M.G.L. c. 118G.

Discontinued Service. A health service, supply or accommodation which:
(a) is included in the adjusted base year cost and which will not be offered during the rate year, or
(b) is being offered and terminated during the rate year.

Direct Cost. The cost of a health service, supply or accommodation, excluding administrative, overhead and capital costs.

Division of Medical Assistance (Division). An agency of the Commonwealth of Massachusetts under M.G.L. c. 18E.

Gross Patient Service Revenue (GPSR). The total dollar amount of a hospital's charges for services rendered during the reporting period, generally within a fiscal year.

Intermediate Year. The hospital fiscal year just before the current rate year.

Non-acute Hospital. A hospital that is defined and licensed under M.G.L. c. 111, s. 51, with less than a majority of medical surgical, pediatric, maternity and obstetric beds, or any psychiatric facility licensed under M.G.L. c. 19, s. 29.

Payment on Account Factor (PAF). A percentage applied to charges to calculate a purchaser's discounted Payment level.

Rate Year. The rate year will be 7/1 to 6/30.

Reasonable Financial Requirements (RFR). The sum of a hospital's rate year operating requirements, rate year capital requirements, and rate year working capital requirements.

Recipient. A person determined by the Division to be eligible for medical assistance under the Medicaid Program.

State-Owned Nonacute Hospital. A hospital that is operated by the Massachusetts Department of Public Health (DPH) with less than a majority of medical-surgical, pediatric, maternity, and obstetric beds, or any psychiatric facility operated by the Department of Mental Health (DMH).

Transfer of Cost. An increase (transfer on) or decrease (transfer off) of hospital costs related to persons or entities that provide hospital care or services, and which change compensation arrangements from non-hospital based to hospital based (transfer on) or from hospital based to non-hospital based (transfer off). A transfer on of physician compensation will only be allowed if reasonable.

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III. Medicaid Payment Methodology for State-Owned Nonacute Hospitals

For any particular rate year, a provider-specific Medicaid payment-on-account factor (PAF) will be calculated. This PAF is, in turn, applied to charges billed to the Division by the hospital. The PAF is the result of dividing the ratio of the hospital's rate year allowable costs, called "RFR" by the rate year total charges, called "GPSR". The process required to determine the Medicaid payment-on-account factor involves the following steps:

- o the determination of allowed base-year costs;
- o the adjustment of allowed base-year costs to the rate year;
- o the determination of reasonable financial requirements (RFR) for the rate year; and
- o the determination of approved gross patient revenue service for the rate year.

Each of these steps is explained in greater detail below.

III.A. Determination of Allowed Base-Year Costs

Each hospital must file with DHCFP reports of its costs, revenues, statistics, charges, and other related information in accordance with time frames and reporting mechanisms specified by DHCFP.

1. Allowed Capital Costs.

The base-year allowed capital cost is calculated as the sum of the base year cost of depreciation expense for building and fixed equipment, reasonable interest expense, amortization and leases and rental of facilities, subject to the following limitation.

- (a) interest expense attributable to balloon payments on financed debt will not be allowed. Balloon payments are those in which the final payment on a partially amortized debt is scheduled to be larger than all preceding payments. Requests for interest associated with balloon-type payments must be adjusted to

conform to the time period for conventional regular installment loans.

- (b) Where there has been a change of ownership after July 18, 1984, the allowable basis of the fixed assets to be used in the determination of the depreciation and interest expense shall be the lower on the acquisition cost to the new owner or the basis allowed for reimbursement purposes to the immediate prior owner. The allowed depreciation expense shall be calculated using the full useful lives of the assets.
- (c) All costs (including legal fees, accounting, and administrative costs, travel costs and the costs of feasibility studies) attributable to the negotiation or settlement of the sale or purchase of any payer, and which have been included in any portion of the RFR, shall be subtracted from the capital requirement.

2. Allowed Operating Costs

- (a) The base-year allowed operating costs are established using actual 1993 fiscal year operating costs. This includes only costs incurred or to be incurred in the provision of hospital care and services, supplies, and accommodations and determined in accordance with the Principles of Reimbursement for Provider Costs under 42 U.S.C. ss. 1395 et seq. as set forth in 42 CFR 413 et seq. and the Provider Reimbursement Manual as well as Generally Accepted Accounting Principles.
- (b) The base-year allowed operating costs do not include costs of personnel or consultants where the primary purpose is, either directly or indirectly, to persuade or seek to persuade hospital employees to support or oppose unionization.
- (c) The base-year allowed operating costs shall be adjusted whenever an audit discloses that base year operating costs expended by a hospital were not reasonable and

necessary for the care of publicly-aided patients and did not meet the standards set forth in Section III.A.2.a of this State Plan Amendment. The base-year allowed operating costs shall also be adjusted for discontinued costs and transfer of costs since the base year.

III.B. Adjustment of Allowed Base-Year Costs to the Rate Year

Allowed base-year operating and capital costs are adjusted for additional costs projected to occur in the rate year. These additional costs fall into the major categories of inflation, volume, costs beyond control (CBC), new services and capital.

1. Inflation

The allowed base-year operating costs is adjusted using a composite index comprised of two cost categories: labor and non-labor. These categories shall be weighted according to the weights used by the Health Care Financing Administration for PPS-exempt hospitals. The inflation proxy for the labor cost category shall be the Massachusetts Consumer Price Index. The inflation proxy for the non-labor category shall be the non-labor portion of the HCFA market basket for hospitals. The composite inflation index will be increased by .02 in conformance with prior years' rate calculations.

2. Volume

Allowed base-year operating costs shall be further adjusted to reflect reasonable volume increases and decreases as follows:

- (a) DHCFP has required each hospital to report its costs, revenue, and volume data in accordance with its reporting requirements. For purposes of calculating the volume adjustment, the Allowed Unit Cost for each cost center shall equal the base year direct and indirect costs for that cost center divided by the year units. The volume associated with a Determination of Need (DoN) project, new service, or transfer on of cost shall be part

of the volume used in the computation of the volume allowance. Any allowance due to new services, DoN, or transfer-on volume shall be netted out if the costs associated with it are submitted as new services, CBCs or transfers.

- (b) For projected volume increases or decreases from the intermediate year to the rate year which are greater or equal to 10%, the hospital must submit a supporting statement of explanation accompanied by the appropriate statistical documentation. No volume increase shall be allowed without such explanation and documentation.
- (c) For routine inpatient care services and routine ambulatory services, the allowed marginal cost for a unit increase or decrease in volume shall be 50%. The allowed cost for marginal cost for ancillary services for a unit increase or decrease in volume shall be 60%. There shall be no upside corridors for volume increases.
- (d) An increase in costs due to an increase in routine inpatient services or routine ambulatory services volume from the base year to the rate year shall be calculated as the product of the projected increase in units multiplied by 50% of the allowed unit cost inflated by the base to rate year composite inflation index.

An increase in costs due to an increase in ancillary services volume from the base year to the rate year shall be calculated as the product of the projected increase in units multiplied by 60% of the allowed unit cost inflated by the base to rate year composite inflation index.

- (e) For routine inpatient care services, routine ambulatory services and ancillary services, the allowed marginal cost for a unit decrease in volume shall be as follows:

Unit Decrease
Cost

Allowed Marginal

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Up to 5%	100%
Over 5% to 25%	50%
Over 25% to 50%	25%
Over 50% to 75%	12.5%
Over 75%	0%

There shall be no downside corridors for volume decreases.

- (f) A decrease in cost due to a decrease in routine inpatient care service, routine ambulatory care services or ancillary services volume shall be calculated as the product of the projected decrease in units multiplied by one minus the applicable marginal cost percentage, as describes above, multiplied by the Allowed Unit Cost inflated by the base to rate year composite inflation index.

3. Costs Beyond Hospital Control (CBCs)

- A. Under specific circumstances, a state-owned non-acute Hospital may request an increase in its allowed base year operating costs to include cost increases due to CBCs. A CBC is an unusual and unforeseen increase in reasonable and allowable costs which is solely attributable to unique and exceptional circumstances that are beyond the control of the hospital. The following requirements must be met before certain costs are qualified as CBCs and included in the hospital's operating requirement.

- (1) A cost shall not be determined to be a CBC if in a prior fiscal year the DHCFP approved costs corresponding to the CBC and the events giving rise to the cost did not take place in the year the cost was approved.
- (2) The hospital shall demonstrate that the category of cost of the requested CBC is not included in the adjusted base year operating cost or in the

inflation and volume allowances.

- (3) The timing and amount of the increase in costs must be reasonably certain.
 - (4) A CBC shall be allowable only if the amount requested is greater than one-tenth of 1% of the hospital's total patient care costs.
 - (5) Multiple unrelated CBC requests for any one cost beyond control category must not be grouped together. Each individual CBC request for a particular item must meet the materiality limit specified in (4) above.
 - (6) A CBC shall be allowable only if necessary for the appropriate provision of services to Recipients and if the costs cannot otherwise be met through efficient management and economic operation.
- B. The following are the qualifying incidents or circumstances for CBCs:
- (1) Costs generated by correcting deficiency contingencies or recommendations for failure to comply with changes in government requirements related to hospital licensure and participation in programs of hospital care and services under 42 U.S.C. §§1395 et seq. and 42 U.S.C. §§ 1396 et seq.
An example of this category is a cost incurred or expected to be incurred within six (6) months to comply with a change in the manual issued after 1984 by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Costs of complying with standards contained in the manual before 1985 or costs which merely recommend improvement will not be considered as a CBC. Hospitals which have not previously been accredited by JCAHO will be allowed

reasonable costs of complying with accreditation standards of the JCAHO contained in its manual. An example of cost which would not be considered to be A CBC is expanded emergency room coverage. Also, increased utilization review costs which are not due to any allowable CBC shall not be recognized. Documentation shall include a copy of the government requirement or contingency/recommendation, verification of the increased costs and verification that the increased costs are reasonable to meet the government requirement.

- (2) Costs generated by compliance with changes in government requirements which are set forth in federal or state regulations which mandate non-discretionary hospital expenditures. However, if the costs fall within a category encompassed by an inflation factor, it shall not be allowed as a cost beyond reasonable hospital control. Documentation shall include a copy of the government requirement or contingency/recommendation, verification of the costs, and verification that the increase in costs requested is reasonable to meet the government requirement.
- (3) Costs generated by disaster losses in excess of insurance or extraordinary costs related to disaster losses not covered by outside sources. Documentation shall include verification of loss or extraordinary cost and the insurance or outside source payment. If, however, the loss or extraordinary cost is caused by a facility being inadequately insured according to the standards of the hospital industry, or through negligence on the part of hospital management, such losses or costs shall not be approved.

- (4) Allowed operating costs associated with a major capital expenditure or substantial change in services which is subject to and has received a determination of need pursuant to M.G.L. c. 111, §§25B - 25G. These costs must be segregated from other allowed operating costs. The hospital must demonstrate that the increased cost requests are reasonable. The hospital will not be permitted to make a volume adjustment for departments affected by a determination of need if the hospital requests that the operating cost associated with the determination of need be included as a CBC. Any volume allowance due to DoN shall be netted out if costs associated with it are submitted as a CBC.
- (5) Wage parity adjustments resulting from mergers which are clearly demonstrated to be cost-effective. The term "cost-effective" used in this context shall mean that at the end of three years the merged hospitals are spending less than the individual hospitals have projected, and in no event are spending more than the combined projections of both hospitals. Documentation shall include a copy of the merger agreement and projections of costs without the merger as well as projection of the cost savings to be achieved through the merger. This adjustment will be considered a non-recurring cost beyond control and the costs associated with it will be subtracted from rate year costs for any year in which the rate year becomes the base year for future rates.
- (6) Intra-hospital wage and salary adjustments which are clearly demonstrated to be cost-effective. The term "cost-effective" as used in this context shall mean that at the end of three years the hospital is spending less than it would have without the wage and salary adjustments.

- (a) Documentation shall provide a projection of the costs savings to be achieved as a result of adjustments to wages and salaries.
 - (b) This adjustment will be considered a non-recurring cost beyond control. Costs associated with this CBC will be subtracted from rate year costs for any year in which the rate year becomes the base year for future rate years.
- (7) Costs for reasonable increases in direct care staff salaries and wages in excess of the amount allowed through inflation. This CBC is not to exceed actual expenditures for such increases.
 - (a) Wage relief may be requested for technicians, nurses, nursing aides, orderlies, attendants, occupational therapists, speech therapists, recreational therapists, physical therapists, and respiratory therapists. Any personnel in these categories who are primarily conducting administrative job duties and are not directly involved with providing patient care are not eligible for CBC allowance.
 - (b) The CBC for reasonable increases in direct care staff salaries and wages is defined as the reasonable rate year wage rate less the inflated base year wage rate, times the lesser of the rate year FTE direct care labor force or the base year FTE direct care labor force.
 - (c) The inflation allowance for direct care staff includes the full amounts granted in Section III.B.1.

- (d) The reasonable rate year wage shall be the level of increase required to attract sufficient staff to ensure minimum availability of care as determined by the Department of Public Health for current patients. The wage rate will be determined by the Division with reference to average rates prevailing at other hospitals within the same Medicare labor market region, subject to the following conditions:
- (i) Outlier wage rates as defined by the Division shall be excluded from the computation;
 - (ii) Special weight shall be given to rates prevailing at non-acute hospitals located in the hospital's Medicare labor market region;
 - (iii) If it can be demonstrated that direct care staff at a hospital are transferring in significant numbers to another competing hospital, then the wage rates prevailing at that competing hospital shall be given special weight; and
 - (iv) In no case shall the reasonable rate year wage rate used in this calculation exceed the wage rate actually prevailing at hospitals located in the hospital's Medicare labor market region at the time of application.
 - (v) The determined Medicare Labor Market Regions and their associated

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counties are as follows:

<u>Medicare Labor Market Region</u>	<u>Counties</u>
Eastern Mass	Bristol Essex Middlesex Norfolk Plymouth Suffolk Worcester
Berkshire Springfield	Berkshire Hampden Hampshire
Barnstable	Barnstable Dukes Nantucket
Rural	Franklin

- (e) In order to be eligible for this exception, a hospital must demonstrate that it is facing extraordinary difficulties in the market for direct care staff, as indicated by one or more of the following criteria:
- (i) existence of significant vacancy rates for a period of time sufficient to jeopardize the welfare of patients according to Department of Public Health standards, Joint Commission on Accreditation of Health Care Organizations standards or other qualifying guidelines utilized in Massachusetts to ensure adequate care;
 - (ii) persistent difficulty in recruitment given bona fide recruitment efforts to